CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Administration and Financial Management

(Amendment)

907 KAR 1:604. Recipient cost-sharing.

RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020, 42 C.F.R. 430.10, 431.51, 447.15, 447.21, 447.50, 447.52, 447.53, 447.54, 447.59, 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530, 457.535, 457.570, 42 U.S.C. 1396a, b, c, d, o, r-6, r-8, 1397aa – 1397jj, Social Security Act 1902(a)(10)(A), 1902(a)(52), 1902(aa), 1902(l)(1)(B),(C),(D), 1905(a)(4)(C), 1905(o), 1931, 2006 GA HB 380 [~~2005 GA HB 267~~]

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.51, 447.53, 447.54, 447.55, 447.57, 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5), Public Law 109-171

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments or other similar charges for Medicaid recipients. KRS 205.6485(1) re

quires the cabinet to establish, by administrative regulation, premiums for families with children in the Kentucky Children's Health Insurance Program. 42 U.S.C. 1396r-6(b)(5) allows for a monthly premium in the second six (6) months of transitional medical assistance. This administrative regulation establishes the provisions, including those authorized by Public Law 109-171, relating to imposing and collecting copayments, coinsurance and premiums from certain recipients.

Section 1. Definitions.

(1) "Caretaker relative" means a relative:

(a) With whom a child is, or shall be, placed by the Cabinet for Health and Family Services; and

(b) Who is seeking to qualify as a kinship caregiver.

(2) "Categorically needy children" means individuals under eighteen (18) years of age receiving Title IV-E benefits, SSI, or SSP, or who would have been eligible to receive Title IV-A benefits prior to July 16, 1996.

(3) "Coinsurance" means a percentage of the cost of a Medicaid benefit that a recipient is required to pay.

(4) "Comprehensive choices" means a benefit package for individuals who meet the nursing facility patient status criteria established in 907 KAR 1:022, receive services through either a nursing facility in accordance with 907 KAR 1:022, the acquired brain injury waiver program in accordance with 907 KAR 3:090, the home and community based waiver program in accordance with 907 KAR 1:160 or the model waiver II program in accordance with 907 KAR 1:595.

(5) "Copayment" means a dollar amount [~~that~~] portion of the cost of a Medicaid bene-

fit [~~service~~] that a recipient is required to pay.

(6) [~~(2)~~] “Department” means the Department for Medicaid Services or its designee.

(7) [~~(3)~~] "Drug" means a covered drug provided in accordance with 907 KAR 1:019 for which the Department for Medicaid Services provides reimbursement.

(8) “Family choices” means a benefit package for individuals covered pursuant to Section 1902(a)(10)(A)(i)(I) and 1931 of the Social Security Act, Section 1902(a)(52) and 1925 of the Social Security Act (excluding children eligible under Part A or E of title IV), Section 1902 (a)(10)(A)(i)(IV) as described in 1902(l)(1)(B) of the Social Security Act, Section 1902(a)(10)(A)(i)(VI) as described in 1902 (l)(1)(C) of the Social Security Act, Section 1902 (a)(10)(A)(i)(VII) as described in 1902 (l)(1)(D) of the Social Security Act, and 42 CFR 457.310.

(9) “Global choices” means the department’s default benefit package and shall be for the following populations:

(a) Caretaker relatives of children who:

1. Receive K-TAP and are deprived due to death, incapacity or absence;

2. Do not receive K-TAP and are deprived due to death, incapacity or absence; or

3. Do not receive K-TAP and are deprived due to unemployment;

(b) Individuals aged sixty-five (65) and over who receive SSI:

1. But do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. And receive SSP but do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(c) Blind individuals who receive SSI:

1. Who do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

2. And SSP but do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(d) Disabled individuals who receive SSI:

1. Who do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children;

2. And SSP but do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits and are eligible for “pass through” Medicaid benefits but do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits and are eligible for “pass through” Medicaid benefits but do not meet nursing facility patient status in accordance with 907 KAR 1:022; or

(g) Disabled individuals who have lost SSI or SSP benefits and are eligible for “pass through” Medicaid benefits but do not meet nursing facility patient status in accordance with 907 KAR 1:022.

[~~(4) "Emergency condition" means a condition which requires an emergency service pursuant to 42 C.F.R. 447.53.~~

~~(5) "General ophthalmological service" means a service or procedure listed under this heading in the American Medical Association's Current Procedure Terminology (CPT).~~

~~(6) "Long-term care facilities" is defined by KRS 216.510(1).~~]

(10) [~~(7)~~] "KCHIP" means the Kentucky Children's Health Insurance Program.

(11) “KCHIP Children – Medicaid Expansion Program” means a department program established in 907 KAR 4:020.

(12) [~~(8)~~] "KCHIP Children – Separate CHIP Program” [~~Separate Insurance Program"~~] means a health benefit program for individuals with eligibility determined in accordance with 907 KAR 4:030, Section 2.

(13) "Kinship caregiver" means the qualified caretaker relative of a child with whom the child is placed by the Cabinet for Health and Family Services as an alternative to foster care.

(14) “K-TAP” means Kentucky's version of the federal block grant program of Temporary Assistance for Needy Families (TANF), a money payment program for children who are deprived of parental support or care due to:

(a) Death;

(b) Continued voluntary or involuntary absence;

(c) Physical or mental incapacity of one (1) parent or stepparent if two (2) parents are in the home; or

(d) Unemployment of one (1) parent if both parents are in the home.

[~~(9) "Mandatory eligibility group" means a group whose coverage is mandatory under 42 U.S.C. 1396a(a).~~]

(15) [~~(10)~~] "Nonemergency [~~condition~~]" means a condition which does not require an emergency service pursuant to 42 C.F.R. 447.53.

(16) “Non-preferred brand name drug” means a brand name drug that is not on the department’s preferred drug list pursuant to 907 KAR 1:019.

(17) “Occupational therapy” means the practice of occupational therapy pursuant to KRS 319A.010, as covered by the department, and provided by an occupational therapist as defined in KRS 319A.010.

(18) “Optimum choices” means a benefit package for individuals who meet the intermediate care facility for individuals with mental retardation or a developmental disability patient status criteria established in 907 KAR 1:022, who receive services through either an intermediate care facility for individuals with mental retardation or a developmental disability in accordance with 907 KAR 1:022, or who receive services through the supports for community living waiver program in accordance with 907 KAR 1:145.

(19) “Physical therapy” means physical therapy as defined in KRS 327.010, as covered by the department, and provided by a physical therapist as defined in KRS 327.010 and as covered by the department.

(20) “Preferred brand name drug” means a brand name drug for which no generic equivalent exists and is available via the department’s supplemental rebate program pursuant to 907 KAR 1:019.

[~~(11) "Optional eligibility group" means a group whose coverage is:~~

~~(a) Not identified as mandatory under 42 U.S.C. 1396a(a); and~~

~~(b) Is established as optional pursuant to 42 U.S.C. 1396a(a) or 42 U.S.C. 1396a(a).~~]

(21) [~~(12)~~] "Premium" means an amount paid periodically to purchase health care benefits.

(22) [~~(13)~~] "Recipient" is defined in KRS 205.8451 and applies to [~~means~~] an individual who has been determined eligible to receive benefits under the state’s Title XIX or Title XXI program in accordance with 907 KAR Chapters 1 through 4.

(23) “Speech therapy” means the practice of speech pathology as defined in KRS 334A.020, as covered by the department, and provided by a speech-language pathologist as defined in KRS 334A.020.

(24) “SSI” means the Social Security Administration program named supplemental security income.

(25) “SSP” means state supplemental payments for individuals who are aged, blind or disabled and in accordance with 921 KAR 2:015.

(26) [~~(14)~~] "Transitional medical assistance" or "TMA" means an extension of Medicaid benefits for up to twelve (12) months for families who lose Medicaid eligibility solely because of increased earnings or hours of employment of the caretaker relative or loss of earning disregards in accordance with 907 KAR 1:011, Section 5(8)(b).

Section 2. Comprehensive Choices Copayments and Coinsurance.

(1) Following is a grid establishing comprehensive choices copayment and coinsurance amounts, except for individuals excluded pursuant to Section 6(1) of this administrative regulation, and corresponding provider reimbursement deductions:

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted from Provider Reimbursement
Acute inpatient hospital admission	$10 copayment	Full amount of the copayment
Outpatient hospital or ambulatory surgical center visit	$3 copayment	Full amount of the copayment

Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage	$1 copayment	Full amount of the copayment
Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage	$2 copayment	Full amount of the copayment
Non-preferred brand name drug for a recipient who does not have Medicare Part D drug coverage	Five (5) percent coinsurance	Full amount of the coinsurance

Emergency room for a non-emergency visit	Five (5) percent coinsurance	Full amount of the coinsurance
Durable Medical Equipment	Three (3) percent coinsurance up to a maximum of $15	The amount of the coinsurance or, if applicable, $15
Podiatry office visit	$2 copayment	Full amount of the copayment

(2) A recipient shall not be liable for more than:

(a) $225 per calendar year for prescription drug copayments or coinsurance; or

(b) $225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

Section 3. Family Choices Copayments and Coinsurance.

(1)(a) Only KCHIP Children - Medicaid Expansion Program and KCHIP Children - Separate CHIP Program individuals, except for any individual excluded in accordance with Section 6(1), shall be family choices individuals subject to copayments or coinsurance;

(b) Following is a grid establishing copayment and coinsurance amounts, for individuals referenced in paragraph (a) of this subsection along with corresponding provider reimbursement deductions:

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted

		from Provider Reimbursement
Allergy service or testing (no copayment exists for injections)	$2 copayment	Full amount of copayment
Generic prescription drug or atypical anti-psychotic drug if no generic equivalent exists	$1 copayment	Full amount of copayment
Preferred brand name drug	$2 copayment	Full amount of copayment
Non-preferred brand name drug	$3 copayment	Full amount of the copayment
Emergency room for a non-emergency visit	Five (5) percent coinsurance	Full amount of the coinsurance

(2) A recipient shall not be liable for more than:

(a) $225 per calendar year for prescription drug copayments or coinsurance; or

(b) $225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

Section 4. Global Choices Copayments and Coinsurance.

(1) Following is a grid establishing global choices copayment and coinsurance amounts, except for individuals excluded pursuant to Section 6(1) of this administrative

regulation, and corresponding provider reimbursement deductions:

Benefit	Copayment or Coinsurance	Copayment or Coinsurance Amount Deducted from Provider Reimbursement
Acute inpatient hospital admission	$50 copayment	Full amount of copayment
Outpatient hospital or ambulatory surgical center visit	$3 copayment	Full amount of copayment
Laboratory, diagnostic or radiology service	$3 copayment	Full amount of copayment
Physician office visit	$2 copayment	No deduction
Visit to a rural health clinic, a primary care center, or a federally qualified health center	$2 copayment	Full amount of copayment
Dental office visit	$2 copayment	No deduction
Occupational therapy	$2 copayment	Full amount of the copayment
Physical therapy	$2 copayment	Full amount of the copayment
Speech therapy	$1 copayment	Full amount of the

		copayment
Chiropractic office visit	$2 copayment	Full amount of the copayment
Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage	$1 copayment	Full amount of the copayment
Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage	$2 copayment	Full amount of the copayment
Non-preferred brand name drug for a recipient who does not have Medicare Part D drug coverage	Five (5) percent coinsurance	Full amount of the coinsurance
Emergency room for a non-emergency visit	Five (5) percent coinsurance	Full amount of the coinsurance
Durable medical equipment	Three (3) percent coinsurance not to exceed	The amount of the coinsurance or, if

	$15	applicable, $15
Podiatry office visit	$2 copayment	Full amount of the copayment

(2)(a) A physician office visit includes an office visit for care provided by a physician, a certified pediatric and family nurse practitioner, a nurse midwife, an advanced registered nurse practitioner, or a physician assistant.

(b) A physician office visit excludes a visit to a federally-qualified health center, rural health clinic, or a primary care center.

(3) Behavioral health services include mental health rehabilitation or stabilization, behavioral support, psychological services and inpatient psychiatric services.

(4) A recipient shall not be liable for more than:

(a) $225 per calendar year for prescription drug copayments or coinsurance; or

(b) $225 per calendar year for service copayments or coinsurance.

(5) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

Section 5. Optimum Choices Copayments and Coinsurance.

(1) Following is a grid establishing optimum choices copayment and coinsurance amounts, except for individuals excluded pursuant to Section 6(1) of this administrative regulation, and corresponding provider reimbursement deductions:

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted from Provider Reimbursement
Acute inpatient	$10 copayment	Full amount of the copayment

hospital admission		
Outpatient hospital or ambulatory surgical center visit	$3 copayment	Full amount of the copayment
Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage	$1 copayment	Full amount of the copayment
Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage	$2 copayment	Full amount of the copayment
Non-preferred brand name drug for a	Five (5) percent coinsurance	Full amount of the coinsurance

recipient who does not have Medicare Part D drug coverage		
Emergency room for a non-emergency visit	Five (5) percent coinsurance	Full amount of the coinsurance
Durable Medical Equipment	Three (3) percent coinsurance up to a maximum of $15	The amount of the coinsurance or, if applicable, $15
Podiatry office visit	$2 copayment	Full amount of the copayment

(2) A recipient shall not be liable for more than:

(a) $225 per calendar year for prescription drug copayments or coinsurance; or

(b) $225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

Section 6. Copayment, Coinsurance and Premium General Provisions and Exclusions.

(1) The department shall impose no cost sharing for the following:

(a) A service furnished to an individual under eighteen (18) years of age required to be provided medical assistance under Social Security Act 1902(a)(10)(A)(i),

including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Title IV, Part E, without regard to age;

(b) A preventive service (for example, well baby and well child care and immunizations) provided to a child under eighteen (18) years of age regardless of family income;

(c) A service furnished to a pregnant woman, if the service relates to the pregnancy or to any other medical condition which may complicate the pregnancy;

(d) A service furnished to a terminally ill individual who is receiving hospice care as defined in Social Security Act 1905(o);

(e) A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with mental retardation or a developmental disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;

(f) An emergency service as defined by 42 CFR 447.53;

(g) A family planning service or supply as described in Social Security Act 1905(a)(4)(C); or

(h) A service furnished to a woman who is receiving medical assistance via the application of Social Security Act 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

(2) The department has determined that any individual liable for a copayment, coinsurance amount or premium shall:

(a) Be able to pay a required copayment, coinsurance amount or premium; and

(b) Be responsible for a required copayment, coinsurance or premium.

(3) A provider shall not waive a copayment, coinsurance amount or premium obligation as imposed by the department for a recipient.

(4) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor or agent of a pharmaceutical manufacturer, shall not make a copayment or coinsurance amount for a recipient.

(5) A parent or guardian shall be responsible for a copayment, coinsurance amount or premium imposed on a dependent child under the age of twenty-one (21).

(6) Provisions regarding a provider's ability to deny a service or benefit based on a recipient's failure to make a required copayment or coinsurance payment shall be as established in KRS 205.6312(4) and House Bill 380 of the 2006 Session of the General Assembly and in accordance with Public Law 109-171.

(7) A provider:

(a) Shall collect from a recipient a copayment, coinsurance amount or premium as imposed by the department for a recipient in accordance with this administrative regulation;

(b) Not waive a copayment, coinsurance amount or premium obligation as imposed by the department for a recipient; and

(c) May collect a copayment, coinsurance amount or premium at the time a benefit is provided or at a later date.

(8) Cumulative cost sharing for premium payments and copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be lim-

ited to five (5) percent of annual family income.

(9) A monthly premium for a family who receives benefits under 42 U.S.C. 1396r-6(b) shall not exceed three (3) percent of:

(a) The family's average gross monthly income; or

(b) The family's average gross monthly income minus the average monthly costs of child care necessary for the employment of the caretaker relative.

(10) The department shall not increase its reimbursement to a provider to offset an uncollected copayment, coinsurance amount or premium from a recipient.

(11) The copayment and coinsurance provisions established in this administrative regulation shall supersede any copayment or coinsurance provision in any other department administrative regulation if any contradiction exists.

[~~Prescription Drug Copayments.~~

~~(1) Except as excluded in Section 4 of this administrative regulation, the department shall require a prescription drug copayment from a Medicaid recipient in a mandatory eligibility group as follows:~~

~~(a) One (1) dollar for a generic drug prescription and the department shall reduce the provider's reimbursement by one (1) dollar;~~

~~(b) One (1) dollar for an atypical anti-psychotic drug prescription if the atypical anti-psychotic drug has no generic equivalent. The department shall reduce the provider's reimbursement by one (1) dollar;~~

~~(c) Two (2) dollars for a brand name drug prescription if the brand name drug has no generic equivalent and the brand name drug is available under the supplemental rebate program. The department shall reduce the provider's reimbursement by one (1) dollar;~~

~~(d) Three (3) dollars for a nonpreferred brand name drug prescription and the department shall reduce the provider's reimbursement by one (1) dollar.~~

~~(2) Except as excluded in Section 4 of this administrative regulation, the department shall require a prescription drug copayment from a Medicaid recipient in an optional eligibility group as follows:~~

~~(a) Three (3) dollars for a generic drug prescription and the department shall reduce the provider's reimbursement by three (3) dollars;~~

~~(b) Three (3) dollars for an atypical anti-psychotic drug prescription if the atypical anti-psychotic drug has no generic equivalent. The department shall reduce the provider's reimbursement by three (3) dollars;~~

~~(c) Ten (10) dollars for a brand name drug prescription if the brand name drug has no generic equivalent and the brand name drug is available under the supplemental rebate program. The department shall reduce the provider's reimbursement by ten (10) dollars;~~

~~(d) Twenty (20) dollars for a nonpreferred brand name drug prescription and the department shall reduce the provider's reimbursement by twenty (20) dollars.~~

~~Section 3. Service Copayments.~~

~~Except as excluded in Section 4 of this administrative regulation, the department shall require a service copayment from a Medicaid recipient as follows:~~

~~(1) Two (2) dollars per recipient per visit for a visit to a physician office, advanced registered nurse practitioner office, physician assistant office, rural health clinic, primary care center or federally qualified health center regardless of the type of provider that provides a service during the visit. The department shall not reduce the provider's reimbursement by the amount of the copayment;~~

~~(2)(a) Two (2) dollars per recipient per visit to any of the following types of providers:~~

~~1. An audiologist;~~

~~2. A chiropractor;~~

~~3. A dentist;~~

~~4. A hearing aid dealer;~~

~~5. An optician;~~

~~6. A podiatrist;~~

~~7. A general ophthalmologist; or~~

~~8. An optometrist for a general ophthalmological service; and~~

~~(b) The department shall reduce the provider's reimbursement by two (2) dollars for each visit or service identified in paragraph (a) of this subsection;~~

~~(3) Three (3) dollars per recipient per provider per date of service for a visit to an outpatient hospital, excluding a visit for treatment of an emergency condition. The department shall reduce the provider's reimbursement by three (3) dollars;~~

~~(4) Three (3) dollars per recipient per visit to an inpatient hospital or outpatient hospital for treatment of a nonemergency condition. The department shall not reduce the provider's reimbursement by three (3) dollars; and~~

~~(5) Fifty (50) dollars per recipient for an inpatient hospital admission including a direct admission as well as any admission resulting from a transfer.~~

~~(a) The copayment shall be due to the admitting hospital.~~

~~(b) The department shall reduce the provider's reimbursement by fifty (50) dollars.~~]

~~Section 4. Copayment Exclusions and Limits and Recipient and Provider Responsibilities.~~

~~(1) The following annual copayment limits, based on a calendar year, shall apply:~~

~~(a) A recipient shall not be liable for more than $225 in prescription drug copayments per calendar year; and~~

~~(b) A recipient shall not be liable for more than $225 in service copayments per calendar year.~~

~~(2) The following shall not be subject to copayments:~~

~~(a) Exclusions established in KRS 205.6312, 42 C.F.R. 447.53 or 457.535;~~

~~(b) A service provided to a recipient who has reached his or her 18th birthday but has not turned nineteen (19); or~~

~~(c) A service provided to a recipient residing in a long-term care facility.~~

~~(3) An individual receiving services via any of the department's home and community based waiver service programs shall:~~

~~(a) Be subject to prescription drug copayments; and~~

~~(b) Not be subject to service copayments.~~]

~~(4) Unless excluded in subsection (2) or (3) of this section, the department has determined that each Medicaid recipient:~~

~~1. Should be able to pay a required copayment; and~~

~~2. Shall be responsible for a copayment.~~

~~(5) The department shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient.~~

(~~6) Cumulative cost sharing for premium payments and copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of annual family income.~~

~~(7) A monthly premium for a family who receives benefits under 42 U.S.C. 1396r-6(b) shall not exceed three (3) percent of:~~

~~(a) The family's average gross monthly income; or~~

~~(b) The family's average gross monthly income minus the average monthly costs of child care necessary for the employment of the caretaker relative.~~

~~Section 5. Provisions for Collection of Copayments.~~

~~(1) A provider shall collect a copayment from a recipient in accordance with Sections 2, 3, and 4 of this administrative regulation.~~

~~(2) A provider may collect the copayment at the time a service is provided or at a later date.~~

~~(3) A provider shall not refuse to provide a service if a recipient is unable to pay a required copayment. This provision shall not:~~

~~(a) Relieve a recipient of an obligation to pay a copayment; or~~

~~(b) Prevent a provider from attempting to collect a copayment.~~

~~(4) If it is the routine business practice of a provider to terminate future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice.~~

~~(5) A provider shall give advanced notice to a recipient with uncollected debt before services can be terminated.~~

~~(6) A provider shall not waive a copayment obligation as imposed by the department for a recipient.~~

~~(7) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396R-8(k)(5), or a representative, employee, independent contractor~~

~~or agent of a pharmaceutical manufacturer, shall not make a copayment for a recipient.~~

~~(8) A parent or guardian shall be responsible for a copayment imposed on a dependent child under the age of twenty-one (21).~~]

Section 7. [~~6.~~] Premiums for KCHIP Children – Separate CHIP Program Recipients. [~~Separate Insurance Program Recipients.~~]

(1) The department shall require a family with children participating in the KCHIP Separate Insurance Program to pay a premium of twenty (20) dollars per family, per month.

(2)(a) The family of a new KCHIP Separate Insurance Program eligible shall be required to pay a premium beginning with the first full month of benefits after the month of application.

(b) Benefits shall be effective with the date of application if the premium specified in paragraph (a) of this subsection has been paid.

(3) Retroactive eligibility as described in 907 KAR 1:605, Section 2(3), shall not apply to a recipient participating in the KCHIP Separate Insurance Program.

(4)(a) If a family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(b)1. A KCHIP Separate Insurance Program recipient shall be eligible for reenrollment upon payment of the missed premium.

2. If twelve (12) months have elapsed since a missed premium, a KCHIP Separate Insurance Program recipient shall not be required to pay the missed premium before reenrolling.

Section 8. [~~7.~~] Premiums for Transitional Medical Assistance Recipients.

(1) A family receiving a second six (6) months of TMA, whose monthly countable earned income is greater than 100 percent of the federal poverty limit, shall pay a premium of thirty (30) dollars per family, per month.

(2) If a TMA family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the benefit month for which the premium has not been paid unless the family has established to the satisfaction of the department that good cause existed for failure to pay the premium on a timely basis. Good cause shall exist under the following circumstances:

(a) An immediate family member living in the home was institutionalized or died during the payment month;

(b) The family was victim of a natural disaster including flood, storm, earthquake, or serious fire;

(c) The caretaker relative was out of town for the payment month; or

(d) The family moved and reported the move timely, but the move resulted in:

1. A delay in receiving the billing notice; or

2. Failure to receive the billing notice.

Section 9. [~~8.~~] Notices and Collection of Premiums.

(1) Premiums shall be collected in accordance with Sections 7 and 8 [~~6 and 7~~] of this administrative regulation.

(2) The department shall give advance written notice of the:

(a) Premium amount; and

(b) Date the premium is due.

(3) To continue to receive benefits, a family shall pay a premium:

(a) In full; and

(b) In advance.

(4) If a family pays the required premiums semiannually or quarterly in advance, they shall receive a ten (10) percent discount.

Section 10. [~~9.~~] Provisions for Recipients in Medicaid-Managed Care.

(1) A managed care entity:

(a) Shall not impose, on a recipient receiving services through a managed-care entity operating in accordance with 907 KAR 1:705, a copayment, coinsurance or premium that exceeds a copayment, coinsurance or premium established in this administrative regulation ; and

(b) May impose upon a recipient referenced in paragraph (a) of this subsection:

1. A lower copayment, coinsurance or premium than established in this administrative regulation; or

2. No copayment, coinsurance or premium. [~~If a copayment is imposed on a recipient receiving services through a managed-care entity operating in accordance with 907 KAR 1:705, it shall be in accordance with the limitations and provisions established in this administrative regulation.~~]

(2) The premium provisions pursuant to Sections 7 and 8 [~~6 and 7~~] of this administrative regulation shall apply to a recipient receiving services through a managed-care entity operating in accordance with 907 KAR 1:705.

(3) A six (6) month guarantee of eligibility as described in 907 KAR 1:705, Section 3(6) shall not apply to a recipient required to pay a premium pursuant to Section 7 [~~6~~] of

this administrative regulation.

Section 11. [~~10.~~] Freedom of Choice. In accordance with 42 C.F.R. 431.51, a recipient may obtain services from any qualified provider who is willing to provide services to that particular recipient.

Section 12. [~~11.~~] Notice of Discontinuance, Hearings, and Appeal Rights.

(1) The department shall give written notice of, and an opportunity to pay, past due premiums prior to discontinuance of benefits for nonpayment of a premium.

(2)(a) If a family's income has declined, the family shall submit documentation showing the decline in income.

(b) Following receipt of the documentation, the department shall determine if the family is required to pay the premiums established in Section 7 or 8 [~~6 or 7~~] of this administrative regulation using the new income level.

(c) If the family is required to pay the premium and the premium has not been paid, the benefits shall be discontinued in accordance with Section 7(4)(a) or 8(2) [~~6(4)(a) or 7(2)~~] of this administrative regulation.

(d) If the family is not required to pay the premium, benefits shall be continued under an appropriate eligibility category.

(3) The department shall provide the recipient with an opportunity for a hearing in accordance with 907 KAR 1:560 upon discontinuing benefits for nonpayment of premiums.

(4) An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

907 KAR 1:604

REVIEWED:

Date

Shannon Turner, J.D., Commissioner
Department for Medicaid Services

Date

Mike Burnside
Undersecretary for Administrative and Fiscal Affairs

APPROVED:

Date

Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

A public hearing on this administrative regulation shall, if requested, be held on August 21, 2006, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by August 14, 2006, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business August 31, 2006. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: 502-564-7905, Fax: 502-564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:604
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes cost-sharing provisions for Medicaid and Kentucky Children's Health Insurance Program (KCHIP) recipients.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish cost-sharing provisions for Medicaid and KCHIP recipients.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 205.6312(5) and Public Law 109-171 (aka the Deficit Reduction Act of 2005) by establishing cost-sharing provisions regarding Medicaid and KCHIP recipients.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation currently assists and will continue to assist in the effective administration of the authorizing statutes by establishing the cost-sharing provisions related to Medicaid and KCHIP recipients.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment is being promulgated to structure Department for Medicaid Services (DMS) cost-sharing in accordance with the Medicaid transformation known as KyHealth Choices. A companion regulation, 907 KAR 1:900E (KyHealth Choices Benefit Packages), will re-design the Kentucky Medicaid program into one tailored to individual needs and circumstances. The benefit packages established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs.

This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with the Deficit Reduction Act of 2005, is necessary to maintain the viability of the program, to provide innovative opportunities to Medicaid and Kentucky Children's

Health Insurance Program (KCHIP) beneficiaries, and to promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to assist in transforming the Medicaid program in conjunction with a related administration regulation - 907 KAR 1:900E (Ky-Health Choices Benefit Packages). This action is necessary to maintain the viability of the Medicaid program and to transform it into a program tailored to beneficiaries' needs. The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation conforms to the content of the authorizing statutes, including KRS 205.6312 and Public Law 109-171 (aka the Deficit Reduction Act of 2005), by assisting in transforming the Medicaid program to maintain its viability and to transform it into a program tailored to beneficiaries' needs. The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation conforms to the content of the authorizing statutes, including KRS 205.6312 and Public Law 109-171 (aka the Deficit Reduction Act of 2005) by assisting in transforming the Medicaid program to maintain its viability and to tailor it to beneficiaries' needs. The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect all Medicaid and KCHIP program beneficiaries.

(4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: All Medicaid and KCHIP program beneficiaries will be affected by this administrative regulation in that they will experience a new cost-sharing structure tailored to their individual circumstances. The benefit packages established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs; family choices is designed for children; global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental re-

tardation or developmental disabilities level of care needs. Additionally, the transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles and personal accountability.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: DMS anticipates that this amendment will generate a savings of approximately $31.1 million ($21.1 million federal funds; $10.0 million state funds) during State Fiscal Year (SFY) 2007.
(b) On a continuing basis: DMS anticipates that this amendment will generate a similar but higher level of annual savings in subsequent years.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX, and matching funds of general fund appropriations and collections will be used to fund the implementation and enforcement of this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: A funding increase is unnecessary; however, an increase in certain designated cost-sharing amounts or imposition of new cost-sharing requirements is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation increases and imposes certain designated cost-sharing requirements.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

This administrative regulation includes tiering in order to tailor the cost-sharing provisions to individual medical needs and circumstances and to assist in transforming the Medicaid program in conjunction with a related administration regulation - 907 KAR 1:900 (KyHealth Choices Benefit Packages). The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

FEDERAL MANDATE ANALYSIS COMPARISON

Reg. No. 907 KAR 1:604

Agency Contact: Stuart Owen or
Stephanie Brammer-Barnes (502-564-6204)

1. Federal statute or regulation constituting the federal mandate.
Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.

This administrative regulation complies with federal statutes and regulations, including Public Law 109-171, governing the Medicaid program including the domain of recipient cost sharing.

2. State compliance standards.
This administrative regulation complies with KRS 205.6312(5) by establishing cost-sharing provisions for Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o. This administrative regulation complies with KRS 205.6485(1) by establishing the premium contribution per family of health insurance coverage available under the Kentucky Children's Health Insurance Program.

3. Minimum or uniform standards contained in the federal mandate.
This administrative regulation establishes cost-sharing provisions for Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o, and Public Law 109-171.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?
This administrative regulation does not impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.
The amendment is necessary to assist in transforming the Medicaid program in conjunction with a related administration regulation - 907 KAR 1:900 (KyHealth Choices Benefit Packages). This action is necessary to maintain the viability of the Medicaid program, to render it better oriented to recipient individual needs while best utilizing the resources available to the Medicaid program.